Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting	Date:	26 July 2017

Agenda item	Title	Executive Director lead and presenter	Report author
BD/17/095	**Clinical Executive Report**	**Andrew Dean/Rebecca Eastley**	**Hannah Bailey**

This report is for:	
Decision	
Discussion	X
To Note	

History

This report provides the monthly update from the Clinical Executive based on the previous month's activities.

The following impacts have been identified and assessed within this report	
Equality	X
Quality	X
Privacy	X

Executive summary of key issues

Patient Safety – Issues remain with completion of 72 hour management reports and RCA completion compliance. We have seen a slight increase in the number of incidents reported on STEIS this month. This is thought to be due to the improved Multiprofessional approach to decision making.

Clinical Effectiveness – Issues persist with missed doses and blank boxes. Actions are included to address this issue.

Service User and Carer experience – A summary of actions from the community mental health survey results include annual reviews, crisis care and carer involvement

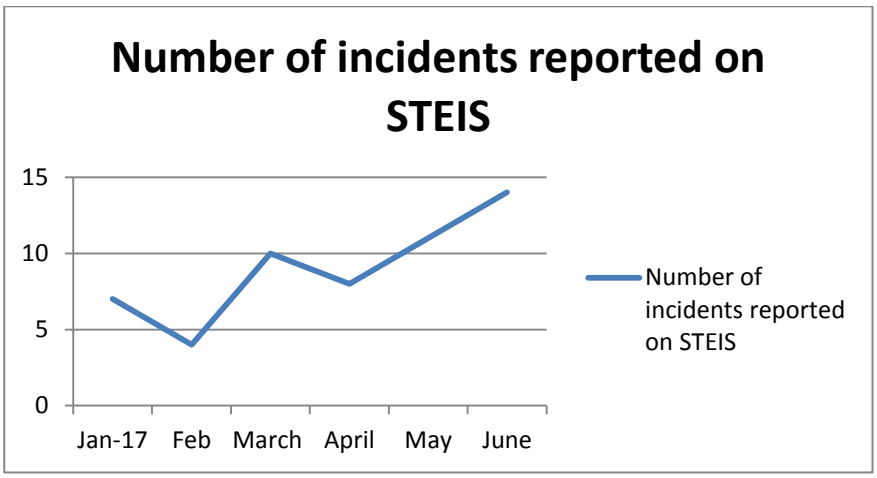
QIP – New items added include falls improvement work and the learning from deaths action plan. 2 exceptions this month are Wiltshire staffing and PERT training compliance

This report addresses these strategic priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	X
We will be future focussed	X

1 Patient Safety

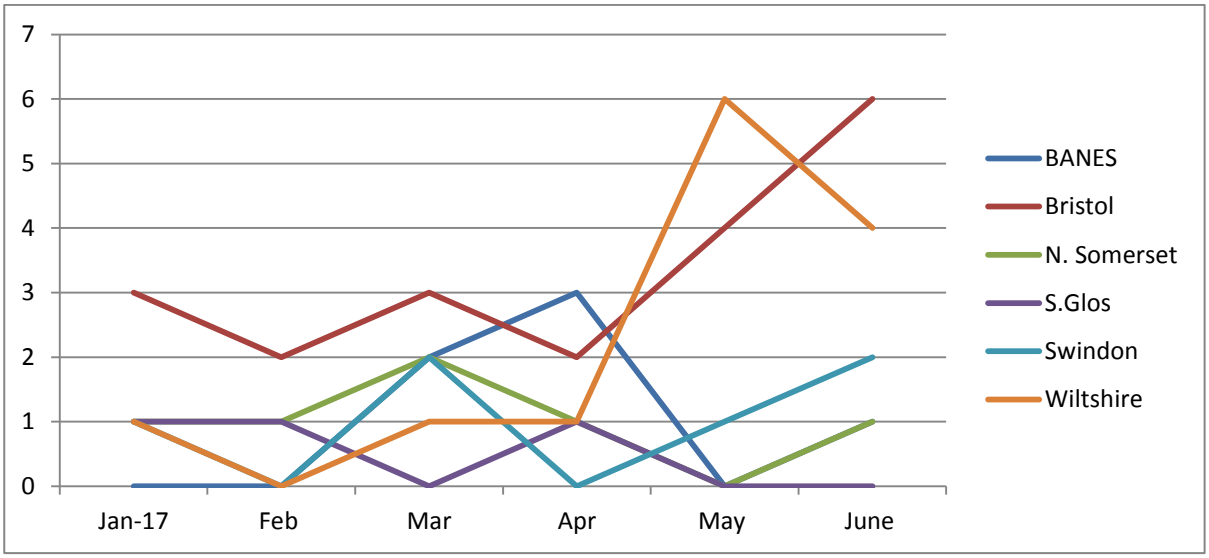
Serious Untoward Incidents

The Trust has reported fourteen incidents on STEIS in June, an increase from eleven reported in May 2017. The Trust has recently implemented an agreed process to identify serious incidents and this is reflected in an increase in the number of incidents reported on STEIS since January 2017.



This information is further broken down by locality in the graph below. The data will continue be monitored for trends and where trends are identified further review will be undertaken to understand the information and identify any relevant learning. The chart reflects an increase in incidents reported from Bristol this month and a decrease from Wiltshire. The potential trend regarding incidents reported from Bristol is noted and will be reviewed regarding themes.

Incidents by locality



The most commonly reported category of serious incidents was suspected community suicide.

There were two serious incidents reported from the same ward, one was an allegation of abuse and the other major disruption to services. Another allegation of this nature from the same ward has recently been reported as a serious incident. As a result a decision was made to close ward for a period of time to enable an investigation to commence. There were two falls reported, both neck of femur; not from the same clinical area. Whilst these two incidents will be investigated, wider work regarding falls risk assessments and management is being undertaken by the Trust falls lead and Quality Improvement facilitator.

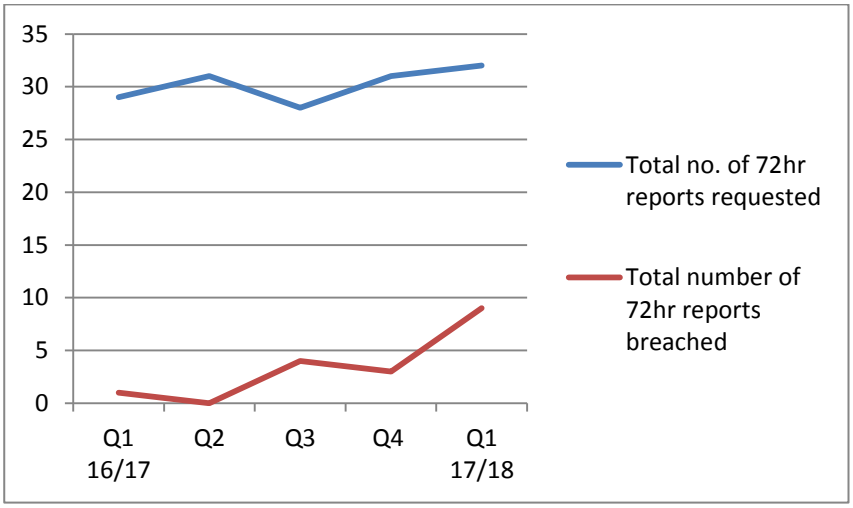
STEIS Performance

The chart below demonstrates that the Trust is continues to experience challenge complying with the national requirement to provide initial incident review findings within the 72 hour timeframe. Three of the delays were due to process issues in the patient safety team, the issue has been reviewed and a solution implemented. The remaining breaches resulted from delay in the report being submitted to the patient safety team; this has been escalated to the operations team and the locality quality directors.

The Trust has implemented the agreed alternative process to review all potential serious incidents, the findings of the reviews will be utilised to inform STEIS. This does not remove the function of the red management report which will continue to be requested to provide detailed information regarding potential serious incidents to inform and support decision making.

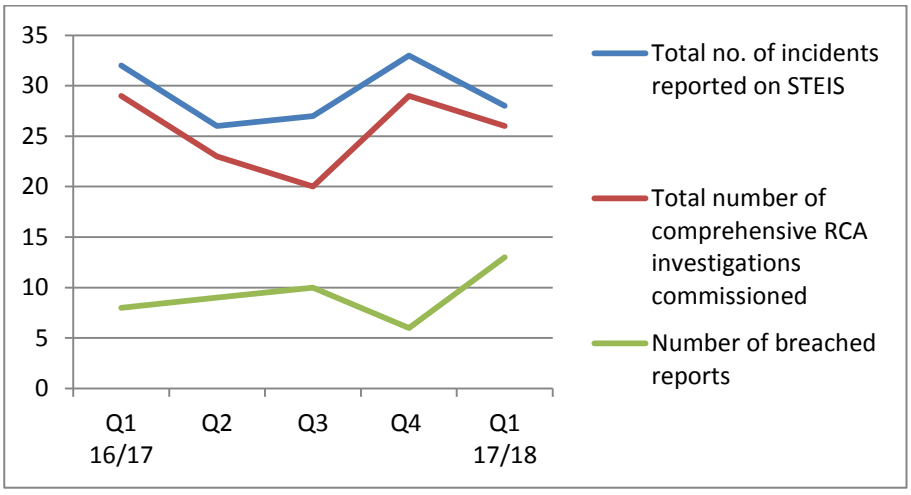
Future reporting of breaches will be by month to provide more timely information.

Number of breached 72 hour reports



Performance regarding completion and submission of serious incident investigation reports within the required 60 day timeframe continues to be challenging for the Trust, this is demonstrated in the chart below.

Number of breached incident reports (STEIS)



** Number of breached incident reports relates to the quarter the investigation report was due.

The volume of investigations undertaken by the patient safety review team is increasing with new appointments to the team. A proposal will be submitted to support a patient safety review team that will manage all serious incident investigation thus standardising the quality of reports and removing the pressure from locality Chairs. Where the patient safety review team do not have capacity to undertake an investigation the senior patient safety reviewer will have oversight of the

progress of the investigation and provide support to the Chair to improve compliance of completion within 60 days.

In conjunction, a ratification committee is being implemented to review all final draft investigation reports and ratify the report prior to sharing with key stakeholders. The committee will be accountable for monitoring compliance of meeting the 60 day submission timeframe as well as scrutiny of the quality of the reports. The committee will meet in July to establish a clear process pathway and commence business.

Learning from incidents

All ratified incidents reports are reviewed at the CIOG meeting. Four reports were reviewed and key learning points identified:

- Embed the recent welfare check process
- Improve timely updating of care plans
- Support service users in the context of holistic approach to cultural needs

Actions will be monitored via QIP.

Mortality Review process

The Trust is currently reviewing and developing a mortality review process. The process will focus on a proportionate review approach based on NHSE recommendations and in line with national timescales.

All suspected suicides and homicides of current service users and deaths of inpatients will be reviewed using a comprehensive root cause analysis investigation. Clearer oversight of the investigations will enable the identification of themes to support Trust wide learning.

Expected deaths and unexpected deaths of natural causes will be reviewed utilising a structured case record review process. Each locality will manage this process using an agreed review template and proportionate review process with a process or identifying themes and escalating concerns.

Governance of thematic learning and exceptions will be provided by the Learning from Incidents Group (CIOG).

Safety Alerts / Red Top Alerts Published

The Trust issued one red top alert and one internal safety alert in June to highlight the following issues:

- Using a service user's letter/assessment/care plan as a template for another service user
- Safe and effective preparation for hospital leave

Alerts share information and identify actions that specific staff are required to undertake in order to minimise future risk. The alerts are circulated to the locality managers with the required actions and uploaded to the Trust intranet (Our space) to enable all staff to have access to the alert. Governance of compliance with the required actions is managed and monitored by the Risk Facilitator System Manager.

CQC Update

The CQC have now completed their focused inspection of our services and have given initial feedback to the Trust's senior management staff. The CQC clearly spoke about the passionate staff they encountered "across the board".

The CQC spent time in a number of Trust teams between 19th and 30th June to check progress against areas that required improvement, as highlighted in their comprehensive inspection in 2016.

These areas included:

- In-patient, Acute and PICU (Trust wide)
- Older people in-patient services (Trust wide)
- Intensive Services (Trust wide)
- Health Based Places of Safety (Trust wide)
- Rehab (Trust wide)
- Well Led as an overall inspection of how the organisation operates leadership, vision, values, governance and assurance.

Next Steps:

The CQC have confirmed that the initial report provided for the Trust will take 4-5 weeks to be completed and will include their findings relating to the section 29A Warning Notice as well as any changes to the domain matrix and any subsequent changes to the overall rating.

The Trust has 10 working days to for accuracy checking and the final report will be published within 5 working days of the return date of the report from AWP to the CQC.

All initial intelligence gained through either staff feedback from inspections on the day or from informal feedback from the CQC will be added to the Trust-wide QIP and responses/actions reported back to the CQC.

External Visits

CQC Mental Health Act Visits

1 visit occurred in May 2017 to the New Horizons mother and baby unit, with the report received from the CQC in June 2017.

The following information was highlighted in the report

Positive

- Excellent patient feedback – patients felt well supported and found staff very helpful and caring
- Care plans were comprehensive and linked to risk assessments
- There was evidence that the code of practice was being adhered to
- IMHA spoke positively about engagement with ward staff
- Calm and nurturing environment
- Staff reported feeling well supported and received regular supervision

Areas for improvement

- An issue with pipes banging which was intrusive. Maintenance attended on the day of the visit to resolve the issue
- Lack of activity provision across 7 days, with weekend being particularly difficult. A full review of activity provision across the Trust is being conducted; currently a scoping exercise has occurred to establish current position and variation in capacity. This data is just being reviewed and recommendations will follow.
- PERT training compliance was 62% on the day of the visit. 5 staff required training. 2 staff are attending training in the next month and 3 are awaiting a space for training. This issue has been raised in all recent MHA visits and actions have been presented in recent clinical executive report. A full action plan is included in appendix 1.

- PMVA training compliance was 42% on the day of the visit. This has been actioned immediately by the team manager. 7 staff required training, 5 staff are booked on training in the near future, 2 staff are exempt for medical reasons. Following this the clinical executive has been exploring the current process for oversight of stat/man training compliance.

Monitoring of Stat/Man Training compliance

The Clinical Executive have requested a review of how locality managers monitor training compliance and received the response below from L&D

- We conduct regular Training Needs Analysis exercises to establish the number of staff out of date on each stat/man subject and the number of staff whose compliance will expire in the period being considered. The two figures are combined and we increase this total to include a small element for turnover and 'do not attendees'. This figure is used to calculate the number of courses to be organised for each locality and staff can book on these courses using the Managed Learning Environment with email confirmation being issued automatically to the member of staff and their line manager.
- On every stat/man subject we do offer significantly more places over and above the calculated number of places required. This is due to the high number of DNAs and unfilled places so constantly having to organise additional courses. We are constantly seeking ways of reducing DNAs and over the last year have driven down the figure from 250+ per month to just over 100 last month. In addition contacting persistent DNA offenders and those staff whose stat/man training is significantly out of date that it is imperative that they are up to date on stat/man training. The main reason for DNAs is business pressure on the day as well as annual leave or sickness.

- On Ourspace each month the Trust provide each locality with compliance figures which can be filtered to individual members of staff as to subjects they are in date, those which are out of date and the expiry date of subjects. This allows localities to chase and remind staff of the need to book on courses relevant to their occupations. Operations managers scrutinise Stat/Man training compliance at locality meetings and centrally at the Operations delivery board.

Laurel Ward – Update of progress following closure

Twice weekly teleconference meetings have been taking place between the Clinical Executive directorate, operations and the triumvirate in Bristol. This has aided communication and effective management of the situation and has been chaired by the Associate Director of Nursing for Inpatients who is leading the project.

Safeguarding:

A safeguarding alert was raised immediately following the disclosure of the allegation of unlawful restriction through locking a service user (MR) in their bedroom. An initial safeguarding strategy meeting was held on the 26/6/2017 which discussed the response to the allegation and initial plans in place for staff and patients, however the Police were unable to attend, and therefore no plan for investigation was able to be agreed.

At the request of the Associate Director for Statutory Delivery (due to the need to agree an investigation plan), a further urgent strategy meeting (through conference call) was held on the 29/6/2017, where the ongoing planning for staff and patients was updated, and the Police confirmed that they would investigate the allegation (as a potential offence under MCA s44). The allocated investigating officer contacted the Trust on the 6/7/2017, and plans have been agreed for the Police investigation to commence on Monday 10/7/2017, facilitated by the locality Quality Director.

A further safeguarding conference meeting has been agreed, but the date has yet to be confirmed

Training Programme:

A 3 week training programme has been implemented for all staff on Laurel Ward, including bank nurses who work at least 1 shift per week on the ward. This includes:-

Observation and engagement, Safeguarding: (Mental Capacity Act and DOLS, What makes a good safeguarding referral), Suicide prevention and risk assessment, Physical Health skills training (including pressure ulcer prevention and management; UTI's, catheter care and diabetes), Falls risk prevention, Medication Management and competency assessment, documentation and care planning, respect and dignity workshops, understanding and managing violence and aggression.

All staff are now up-to-date on all their Stat/Man training.

It was evident from the face-to-face Safeguarding training that staff were not aware fully able to translate the e-learning they had received into practice for either safeguarding adults or mental capacity.

This has now been clarified in the training and how they should use proportionate and least restrictive responses in the service users' best interest.

The Dementia Wellbeing Service in Bristol will be providing ongoing dementia care training and a meeting to look at this programme has been set up for 14th July 2017. There will also be team building sessions. The dementia care consultant nurse will be working on the ward alongside staff 2-3 days per week when the ward re-opens to role model best practice around management of challenging behaviour and other interventions.

Competency assessments:

All staff (including bank staff that work more than 1 shift per week on the ward) have undertaken a competency assessment.

In normal working practice, competency assessments are an ongoing activity that takes place as part of management and clinical supervision. In rare circumstances such as these (especially when there are concerns about the safety or effectiveness of a service) there may be a need for a more structured approach, which is what we have undertaken over the past two weeks.

The assessment included themes around duty of care, reporting concerns, observation and engagement, care plans and record keeping, dementia care.

There was a scoring system and overall staff did very well in these assessments, apart from a band 2 HCA (bank) and a band 6 nurse who is currently on probation. There were development needs identified for both these individuals which have been addressed through the training programme.

Staff found this process extremely supportive as it gave them an opportunity to give feedback on the culture and developmental needs of the ward which has been incorporated into the next stage of the training programme.

Support processes:

All staff have been receiving regular support from nurses in the Clinical Executive directorate, psychology and senior nurses from the ward team. De-brief sessions will take place on Monday 10th and Tuesday 11th July. This will include a separate session for staff that were on duty when the ward closed. Clearly, some of the nursing staff are still extremely distressed, so have really welcomed these de-brief sessions. These will be chaired by external psychologists to Bristol.

Senior clinical leadership:

The new matron for Aspen and Laurel Ward took up post on Monday 3rd July 2017. She attended the ward the previous week at one of the staff meetings chaired by the Associate Director of Nursing for Inpatients, which was positively received by everyone. She has already had a positive impact on staff morale.

Ward opening programme:

The ward has been closed for 3 weeks, and there are no plans to re-open next week. It is expected that a decision will be made at the Clinical Executive team meeting on Tuesday 11th July regarding the future of the ward. Nursing staff will be able to work on other wards on the Callington Road site in the interim.

Aspen Ward:

It has been recognised that there are similar concerns on the 20 bedded functional older peoples ward, and a task group has been set up for Wednesday 12th July with operations and senior nurses from the Clinical Executive directorate to look at competency assessing all staff on the ward and a development programme. This will be achieved by Laurel Ward staff covering shifts on the ward as required.

Safewards update

A process of Safe wards appraisals have been conducted and below is a summary of the findings from the wards completed to date.

Wellow ward instigated a Mutual Help Meeting. Service users present were a little dismissive at first but one service user did engage along with the ward manager Amy Long. The service user got the idea of trying to get along under trying circumstances, but a little difficult to run a Mutual Support Group with one person. The ongoing plan is to run the meeting on an improvised basis, preferably in the morning.

Acer ward are also running a mutual help meeting as a part of their community meeting, and are revising their Clear Mutual Expectations on a regular basis. Community meetings are not optional, but asking and offering for mutual help is. Acer have their tree mural and are using Know Each Other and the Calm down Box.

On Section 136 Mark Earl the Safe wards involvement Worker delivered some coaching work which he designed around 'Life after IM and Seclusion'-how Safe wards can still inform that intervention when we have exhausted all means of verbal communication and how Safe wards can broadly inform work on the unit. They had a constructive coaching conversation about maintaining a caring approach with service users who had committed a violent act. They also discussed the Mutual Help Meeting and how it has proved difficult to encourage service users to take part when in crisis. Know Each Other are in development with the intention to gather reasons why staff do their jobs and this has been inserted in welcome packs.

Aspen Ward, after a quite difficult informal appraisal a few weeks previously, the main link from the ward demonstrated in conversation that they are making some inroads with safe wards and they were able to revise their appraisal. The Link has agreed to do some more constructive work about implementation. The ward manager agreed to place a positive words prompt on hand over forms. Peer supervision groups are being held, which Mark Earl requested to attend and in order to connect with more staff. A Mutual Help Meeting is being held as part of the community meeting. A member of nursing staff is doing some Good work around communication which Mark is linking with.

Oakwood Ward. This was the first meeting between Mark and the Ward after completing their appraisal. The Link acknowledged that the 'softer edged' (i.e. communication interventions) take place as a matter of course, but another staff member was keen to discuss how we evidence them. They are using Safe wards care plans within the broader remit of documentation of service user progress. The staff were very adamant about use of positive words setting up staff for the next shift in a positive light. Mark encouraged the implementation of a Positive Words prompt box on the hand over paperwork. They also discussed use of individual calm down lists of activities where a service user can self soothe if they are feeling heightened or distressed. They went on to talk about Clear Mutual Expectations and how these have proven to be useful at a point of conflict, especially for an individual with Personality Disorder who found having quite firm standards and boundaries more constructive. Clear Mutual Expectations are included in the service user welcome pack. They talked about the Know Each Other intervention, Mark's previous ward contact had developed this, but it was apparently torn up on the ward by one of the service users.

The ward would really appreciate calm down items box having spent their budget on the relaxation chair- This is being actioned.

Cove ward. Mark Supplied the 'evidencing media' he developed, as well as the individual templates for staff to reflect on using the 'communication interventions'. Mark also supplied the service user questionnaires. The Ward Link agreed to review Clear Mutual Expectations on a regular basis, and to be negotiable around using Positive Words and prompting this at handover. There is lots of qualitative evidence that the ward is amenable to using the interventions especially when resorting to using seclusion with one service user in particular who was very challenging, but using the interventions were able to make agreement about behaviours and expectation of how to be treated. This tied in very well with using the coaching work Mark designed about 'Life after IM and Seclusion'. Reassurance is consciously practiced when conveying difficult decisions to service users and carers- the ward staff are very careful about language, and the broader MDT are engaging with Safe wards thinking. They are using the Know Each Other folder, and they have their wave mural with bottles for templates to post.

Juniper ward. Mark met with the ward manager and a staff nurse for the informal appraisal, both very thoughtful and constructive about moving Safe wards forward. The new safe wards champion hasn't been recruited to as yet due to staff leaving. A new occupational therapist has been identified and will take the role in a few weeks. The ward continues to have individual members of staff to lead on separate interventions.

As mentioned before Mark has been developing some visual media for evidencing Safe wards work on the wards, and as discussed using the 'evidence in one place' media and the individual 'communication interventions' for staff to use at the end of shift or during handover. Mark emphasised about not creating more paperwork, and staff not being hamstrung by being self-conscious about their practice.

The tree mural and Mutual Help is being run weekly by a staff nurse ensuring that they continue with further coaching work, and supporting the wider MDT to develop safe wards awareness.

In Conclusion

Mark has been disseminating the Safe wards service user questionnaires to all wards in Secure services, Bristol, and North Somerset., and he has supplied all the informal appraisals to all ward managers. He has delivered some coaching work on Bradley Brook about Bad News Mitigation and Reassurance, and undertaken some service user feedback on Kennett after which he wrote to the ward manager and the service user concerned. Mark also attended a business meeting at the Wickham unit, where he was able to present his ideas and plans for moving safe wards forward.

A full Safewards report will follow at the August Meeting.

2 Clinical Effectiveness

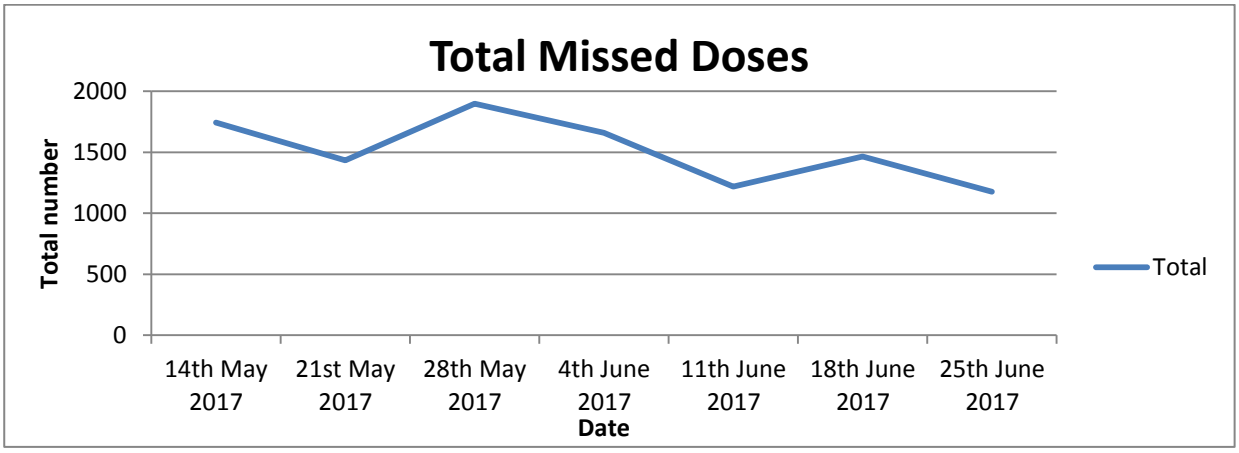
Missed doses & Blank Boxes

Following last month's report which provided clear evidence about the scale of the missed doses issues, the Clinical Executive will provide monthly data about progress in this area. Accurate documentation on the medicines chart is an essential part of patient safety and the Clinical Executive are committed to making improvements in this area. A small group has been formed to further analyse the data and understand the barrier. Further actions including an improvement trajectory will be included in the next report.

Missed Doses:

The number of reported Missed Doses between 4th June to 25th June remains high - averaging 1306, however, this is a reduction in the average when comparing to the previous reported period of 7th May to 4th June that had an average of 1683. Chart 1 below demonstrates the total number of missed doses reported week. It should be noted that although the number of reported missed doses has reduced over the past three weeks the average number of wards engaging in the weekly audits has also reduced to 33 (77%) compared to 37 (86%) in the first four weeks.

Chart 1



Bristol locality had the highest number of missed doses recorded with the lowest recorded in Specialised and CAMHS. The highest numbers of missed doses were noted on some of the later life, PICU and Acute wards across AWP.

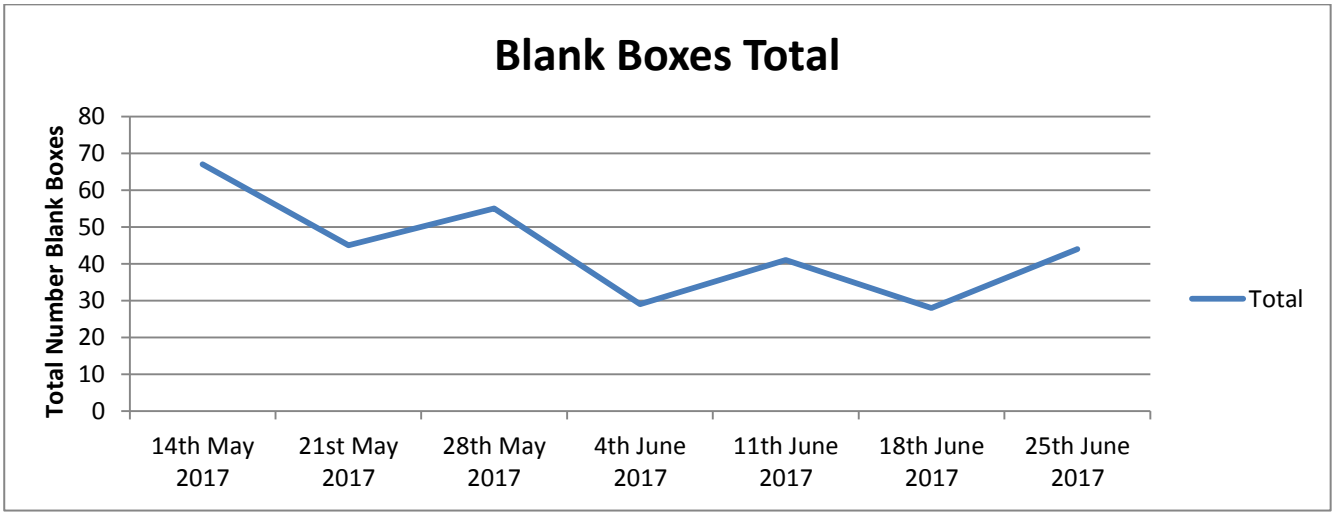
With a total of 3858 missed doses over the past three weeks it has not been possible to provide further analysis of this data.

Blank Boxes:

Chart 3 below demonstrates the number of reported blank boxes has declined since auditing commenced (using a new audit tool) from 67 on 14th May to 44 on 25th June. Numbers have fluctuated each week averaging 44 each week (for the first four weeks this averaged 49 and in the past three weeks has averaged 38). However, as stated with missed doses the number of returns has reduced from 33 (77%) wards to 37 (86%) which therefore creating an issue with interpretation of the data. Actions to improve compliance with audit are being undertaken and driven through the operation team.

South Gloucestershire and CAHMS have not reported any blank boxes (representing one ward each), Banes (representing two wards) and *Secure Services (representing 11 wards) only 1 blank box. In comparison Bristol (representing 10 wards) has reported 62 blank boxes.

Chart 3



Missed Doses & Blank Boxes Planned Actions:

Members of Nursing and Quality met with a representative from Pharmacy on 29th June to review the results of the Missed Dose and Blank Box Audit, and actions have been agreed. With regards to missed doses these actions include access to weekly analysis for managers and

matrons to aid engagement and improvement, redesign of the audit tool making it quicker and easier to complete (which again will aid returns), production of missed doses procedural guidance, production of an agreed critical medicine list and shared learning across wards.

Blank boxes actions include crossed checking against adverse incident reports to elicit if the recommended Escalation Procedure for Blank Boxes is being followed (with the aim of reducing incidents in the future), a deep dive for wards consistently reporting high numbers of blank boxes, shared learning with those wards with low numbers of blank boxes to those with high levels.

3 Service User and Carer Engagement/Experience

The 2016 the national Community Mental Health survey identified four keys areas of improvement for the Trust.

- Annual reviews – Ensure that annual reviews are consistently undertaken
- Crisis care - Continue working to ensure that all service users are given crisis contact details and clarity about what to expect from crisis teams in all localities.
- Other areas of life – Build on improvements for offering help and advice to people for peer support and community engagement. Continue to focus on offering help and support for people getting support for finances, benefits and finding work.
- Carers – Consistently provide appropriate support and information for carers.

An action plan to address the issues has been developed; implementation will be monitored via the QIP and progress reported within this report.

The co-produced service user strategy and action plan has been previously ratified. The action plan has been reviewed in order to risk asses and prioritise and each action, prioritisation will be undertaken with in conjunction with service users. Monitoring of the action plan will be provided by a joint service user and Trust group and reported within this report.

4 QIP

New Items added to the Trust QIP in June are

- The following actions following the analysis of community deaths report. There has been further work to amalgamate all actions from all recent reports bin to one overarching action plan and the QIP will be updated once this has been approved.
    - Improve quality of RCA reports
    - To improve the use of Ulysees for recording and holding information relating to incidents
    - Improve mortality governance
- Falls
    - To review falls training and guidance provided to staff
    - To ensure the post falls checklist is understood and used by staff

The following actions are report as off track ‘red’ this month

- Staffing in Wiltshire – This was reported as ‘red’ last month and actions continue based on the action plan reported in last month’s clinical executive report
- PERT training compliance. Actions are reported as per detailed action plan attached. Further actions are being explored to improve compliance.

PERT training compliance action plan

ACTION PLANNED (06/06/17)	TIMESCALE	Update
External provider capacity: discussions with Able to Train, SWAS and Inspired Better Health in terms of the possibility that they could provide us with some training capacity. This would be a short term arrangement to cover the period of now until October. We agreed that one of these providers could shadow the Head of Resus and then cover a number of identified dates (or co-facilitate to increase numbers). The cost of this is not yet known but will be escalated appropriate once established.	7 July 2017	Ongoing. Discussions ceased with ATT as unable to provide training of the trainer offered. Ongoing discussions with SWAS to cover 3 dates in Salisbury
Head of Resus capacity to deliver training: ADoN to confirm requirement to set at about 5 days/ month (from 8) but that there may be some flexibility in this (i.e. to 6) but that would need further discussion.	30 June 2017	Completed 12/06/17. Capacity confirmed as 5-6 days/month from June 2017.
Management of existing courses: ADoN and Head of Resus to identify which dates the Head of Resus will deliver and which need to be allocated to an external provider to cover	30 June 2017	Completed 12/06/17. Identified 10 dates that Head of Resus could not complete between Aug-Oct. These are currently not covered by external capacity and will be cancelled
Increase capacity of courses: L&D will seek to provide a second trainer with Head of Resus to existing dates to increase capacity.	31 July 2017	Ongoing - Second trainer has been provided for upcoming courses which will increase capacity on current courses
Increase future capacity: All future dates (from November) will be coordinated to provide a second L&D trainer to increase capacity.	30 August 2017	To be completed.
External provider capacity: Deputy DoO suggested contacting other NHS providers i.e. Somerset Partnership or 2gether Partnership to provide additional training	31 July 2017	Complete - L&D contacted providers to scope support and as they outsource they will be unable to provide
Training coordination: Consideration to be given to an automatic recall process for PERT training	September 2017	To be completed.